ARTICLE 32

INSURANCES

Employees will be permitted to enroll in group insurance plans for which they are eligible during their first 31 days of employment. Eligibility for coverage under such plans is the first day of the biweekly pay period after enrollment.

PART A. HEALTH INSURANCE

Section 1. The State Health Plan PPO.

The existing State Health Plan is a PPO plan. In and out-of-network benefits and applicable deductibles and co-payments are outlined in Appendix I.

a. **Premium**: The Employer shall pay the premium for the State Health Plan PPO. Effective 10/3/2010, the Employer shall pay 90% of the premium for the State Health Plan PPO.

b. **Co-pay**: Applicable individual deductibles and co-payments for in and out-of-network services under the State Health Plan PPO are set forth in Appendix I.

c. **Deductibles and Out of Pocket Maximums for The State Health Plan PPO**: The deductibles under the State Health Plan PPO shall be $200/individual and $400/family per calendar year for in-network services and $500/individual and $1,000/family per calendar year for out-of-network services. Effective 1/1/2011 the deductibles shall be $300/Individual and $600/Family for In-Network and $600/Individual and $1,200/Family for Out-of-Network. The maximum out of pocket cost per individual shall be $1,000 and $2,000/family per calendar year for in-network services and $2,000/individual and $4,000/family per calendar year for out-of-network services. The deductible does not apply towards the maximum out of pocket cost.

Section 2. State Health Plan PPO Provisions.

The Association shall continue to be entitled to participate as a member of the Labor Management Health Care Committee.

The committee will continue to review and monitor the progress of the actual implementation of the State Health Plan PPO.

It is understood that each exclusively recognized employee organization will be entitled to designate one representative to participate in the Labor-Management Health Care Committee.

The Plan consists of the following principal components: pre-certification of all hospital inpatient admissions; second surgical opinion; home health care; and alternative delivery systems;

a. **Pre-certification of Hospital Admission & Length of Stay**.
The pre-certification for admission and length of stay component of the Plan requires that the attending physician submit to the Third Party Administrator (TPA) the diagnosis, plan of treatment and expected duration of admission. If the admission is not an emergency, the submission must be made by the attending physician and the review and approval granted by the TPA prior to admitting the covered individual into the acute care facility. If the admission occurs as an emergency, the attending physician is required to notify the TPA by telephone with the same information on the next regular working day after the admission occurs. If the admission is for a maternity delivery, advance approval for admission will not be required; however, the admitting physician must notify the TPA before the expected admission date to obtain the length-of-stay approval. There will be no limitation on benefits caused by the attending physician's failure to obtain pre-admission certification.

b. **Second Surgical Opinion**. An individual covered under the State Health Plan PPO will be entitled to a second surgical opinion. If that opinion conflicts with the first opinion the individual will be entitled to a voluntary third surgical opinion. Second and third surgical opinions shall be subject to a $10 in-network office call fee (Effective 10/1/2010 - $15 co-pay) or covered at 90% after the deductible if obtained out-of-network.

c. **Home Health Care**. A program of home health care and home care services to reduce the length of hospital stay and admissions shall also be available at the employee's option. This component requires that the attending physician contact the TPA to authorize home health care service in lieu of a hospital admission or a continuation of a hospital confinement.

The attending physician must certify that the proper treatment of the disease or injury would require continued confinement as a resident inpatient in a hospital in the absence of the services and supplies provided as a part of the Home Health Care Plan. If appropriate, certification will be granted for an estimated number of visits within a specified period of time. The details of the types of services and charges that shall be covered under this component include part-time or intermittent nursing care by a registered nurse (R.N.) or licensed practical nurse if an R.N. was not available; part-time or intermittent home health aid services; physical, occupational and speech therapy; medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that they would have been covered if the individual had remained or been confined in the hospital.

Home health care services under the SHP~~A~~ will be continued. Details of the covered services will be provided in the SHP PPO benefit booklet. Home Health Care shall be available at the patient's option in lieu of hospital confinement. To receive home health care services, a patient shall not be required to be homebound. Home infusion therapy shall be covered as part of the home health care benefit or covered by its separate components (e.g. durable medical equipment and prescription drugs).

d. **Alternative Delivery Systems**. The State Health Plan PPO shall also provide hospice care and birthing center care benefits to employees and enrolled family members. To be eligible for the hospice care benefit, the covered individual must be diagnosed as terminally ill by the attending physician and/or hospice medical director with a medical prognosis of six months or less life expectancy. Covered hospice benefits include physical, occupational, and speech language therapy; home health aid service; medical supplies; and nursing care. Covered hospice benefits are not subject to the individual deductible or any co-payment and will be paid only for services rendered by federally certified or state licensed hospices. Hospice services covered under the SHP PPO will be continued. Details of the covered service will be provided in the SHP PPO booklet. Both hospice care and birthing center care shall be available to employees at their option in lieu of hospital confinement. Birthing center care is covered under the delivery and nursery care benefits set forth in Appendix I.

e. **Prescription Drugs.** Bargaining unit members who are covered by the State Health Plan PPO will be enrolled in the alternative prescription drug plan. The employer shall continue an optional mail order plan for maintenance prescription drugs. The employee co-pay shall be $7 per prescription for generic drugs, $15 per prescription for brand name drugs, and $30 for non-preferred brand name drugs for both the retail and mail order drug plans. Effective 10/1/2010, the co-pay at retail shall be $10 for generic drugs, $20 for preferred brand name drugs, and $40 for non-preferred drugs. The employee co-pay at mail order shall be two times the retail co-pay. The brand name co-payment level will apply even when there is no generic substitute, as well as to DAW prescriptions. The plan shall provide for an employee identification card, and the required co-payment shall be made to participating providers at the time of drug purchase.

Prescriptions purchased at non-participating pharmacies must be paid for by the plan member who then remits receipts to the vendor for reimbursement. The amount of the reimbursement will not exceed the amount the vendor would have paid to a participating pharmacy and will not include the applicable co-payment.

Zyban and Nicotrol nasal spray for smoking cessation shall be included

under the prescription drug benefit.

All maintenance drugs filled at a participating retail pharmacy will only be approved up to a 34-day supply.

Employees currently taking a non-formulary brand name drug to treat depression, gerd, high cholesterol or high blood pressure, will be offered an opportunity to try the therapeutically equivalent generic and have the co-pay waived for up to six months.

A drug quantity management (DQM) program shall be established to ensure that quantities supplied are consistent with both clinical and dosing guidelines. A member's physician may request an override if the quantity limit is not applicable to the patient and the condition being treated. A list of the specific drugs subject to limitation is on file with the Association and Employer until 9/30/2010. Effective July 1, 2006 all new prescriptions in the DQM program, including refills, will be subject to the quantity limitation.

Effective 10/1/2010, a generics preferred program shall be established whereby if a member chooses a brand name drug when a generic is available the member will pay the brand name co-pay plus the difference in cost between the generic and the brand name drug.

A drug step therapy management program shall be established to promote appropriate utilization of first-line drugs and/or therapeutic categories. Participants will receive one or more first-line drug(s), as defined by the coverage rule, before prescriptions are covered for second-line drugs in defined cases where a step approach to drug therapy is clinically justified. Prior authorization criteria shall be part of the program. Participants shall be "grandfathered" for any second-line drug(s) if they do not break therapy for 130 days.

f. **Mental Health/Substance Abuse Services**

Effective 10/1/2010, Bargaining unit members in the SHP PPO will be enrolled in the same Mental Health / Substance Abuse Plan as other SHP PPO members.

(1) **Outpatient Psychiatric Services:** Reimbursement for outpatient psychiatric services shall be at 90%. Covered charges for the outpatient care by an approved provider of diagnosis, evaluation and treatment of mental and nervous conditions, including drug and alcohol addiction, will be reimbursed as part of The State Health Plan. The applicable co-insurance will be applied to these charges, and a $3500 maximum benefit per year per beneficiary shall be applicable to such charges for drug and alcohol addiction.

(2) **Substance Abuse Treatment:** Substance abuse treatment in licensed facilities for treatment plans not to exceed 28 calendar days duration will be provided under the Plan. Treatment plans exceeding 28 days will be limited to a maximum of 28 days expense coverage.

Employees and covered dependents will qualify for additional in-patient substance abuse treatment after 60 calendar days following discharge for a previous in-patient substance abuse treatment admission. However, expenses incurred from no more than two admissions per calendar year will be covered.

In-patient treatment and charges for room, board and miscellaneous fees will be covered under the Plan as provided below:

(a) Residential Care Facility: 100% of reasonable and customary charges for the standard length of treatment program offered by that facility.

(b) Acute Care Hospital Using Acute Care Beds: 67% of semi-private room and board charges and 100% of covered miscellaneous fees for the standard length treatment program offered by that facility. Charges for detoxification will be paid at 100% of reasonable and customary levels for semi-private room and board and miscellaneous fees.

(c) In the event the patient's physician requires, as part of the treatment plan, that the patient be admitted to an acute care hospital rather than a residential care facility, requests for payment of more than 67% shall be evaluated on a case-by-case basis.

g. **Hearing.** The State's hearing care program shall continue to be a benefit under the State Health Plan PPO. Such program shall include those benefits currently provided, including audiometric exams, hearing aid evaluation tests, hearing aids and fitting and binaural hearing aids when medically appropriate subject to a $10 office call fee (Effective 10/1/2010 $15 Office Call fee) for the examination and shall be available once every 36 months unless hearing loss changes to the degree determined upon advice by the State Health Plan's medical policy team and audiology professionals.

h. **Wellness and Preventive Services.** Wellness and preventive coverage in accordance with the State Health Plan PPO as outlined in Appendix I will be subject to a maximum plan payment of $1,500 for in-network

services per individual per calendar year. There shall be no coverage for wellness and preventive services received out-of-network.

i. **Weight Loss Clinics.** Employees meeting "morbid obesity" criteria are covered by a $300 lifetime weight loss clinic attendance benefit covering those expenses not otherwise covered by the State Health Plan PPO. "Morbid obesity" is defined as more than 50% or 100 pounds over ideal body weight or 25% over ideal body weight with certain medical conditions (such as Diabetes, Heart Disease, Respiratory Disease, etc.).

Note: The $300 amount will not apply to the State Health Plan deductible.

j. **Orthopedic Inserts**. Medically necessary orthopedic inserts for shoes, when prescribed by a licensed physician are covered under the State Health Plan PPO. This benefit is included under the durable medical equipment benefit in Appendix I.

k. **Blood Storage.** The storage cost for self-donated blood for an employee or dependent in preparation for his/her own scheduled surgery is covered by the State Health Plan PPO subject to the individual deductible.

l. **Disease Management Program.** The Blue Health Connection Disease Management Program shall be included under the State Health Plan PPO as a covered benefit on a voluntary basis.

m. **Survivor Conversion Option.** The state recognizes its obligations under federal “COBRA” legislation in case of a “qualifying event”, as defined by that statute.

n. **Skilled Nursing Care Facility.** The skilled nursing facility coverage is 730 days (Effective 10/1/2010 – 120 days) per confinement for employees and dependents.

o. **Subrogation.** In the event that a participant receives services that are paid by the State Health Plan PPO (SHP), the SHP shall be subrogated to the participant’s rights of recovery and shall have a lien on any and all of participant’s recovery, whether by suit, settlement, or otherwise, to the extent that the SHP has paid for medical services related to the matter that is subject to the participant’s claim or action for personal injury. A participant shall take such action, including a good faith effort to pursue recovery of the payments made by SHP, to facilitate enforcement of the rights of the SHP, and shall not interfere with these subrogation rights as set forth herein.

The amount of the SHP lien enforced against a recovery shall not exceed the amount of the recovery allocated for medical services in a judgment or

settlement, nor shall it exceed the actual amount expended by SHP on behalf of the participant for medical services. In every case, the SHP, proportionate to the amount recovered by SHP, shall bear the costs of recovery including attorney fees.

p. **Reimbursement for Certain Services and Equipment.** The reimbursement for in-network private duty nursing and acupuncture therapy shall be 90% after the in-network deductible is met.

Reimbursement for in-network and out-of-network chiropractic spinal manipulation shall be 90% after the deductible is met. Effective 10/1/2010, in-network chiropractic spinal manipulation will be subject to a $15 co-pay and will not be applied toward deductibles.

Reimbursement for durable medical equipment, prosthetic and orthotic appliances, shall be 100% for in-network and 80% for out-of-network.

q. **Office Visits and Consultations.** In-network office visits and office consultations, will be subject to a $10.00 co-pay (Effective 10/1/2010 - $15 co-pay) and will not be applied toward the individual or family deductible. Out-of-network office visits and office consultations shall be covered at 90% after the deductible is met.

r. **In and Out-of-Network Access.** In and out-of-network access is described in Appendix J and attached rules for network use.

s. **Health Maintenance Organizations (HMO's).** As an alternative to the State Health Plan PPO, enrollment in an HMO shall be offered to those employees residing in areas where qualified licensed HMO's are in operation, provided that no employee shall be required to exercise this option. Effective 10/1/2010, The State will pay 95% of the HMO premium up to the dollar contribution paid for the same coverage code under the State Health Plan PPO.

t. **C.O.P.S. Trust.** Effective 10/1/2010 or as soon as administratively feasible, and thereafter during open enrollment, as an alternative to the SHP PPO and HMOs, employees will have the option to enroll in C.O.P.S. Trust. The State will pay the C.O.P.S. Trust premium up to the dollar contribution paid for the same coverage code under the SHP PPO. The Employee will be responsible for any additional costs.

PART B. DENTAL INSURANCE

The State will continue to provide the dental insurance program currently in effect, for employees, and employee/dependent coverage including the following:

Section 1. Orthodontic Services:

a. There shall be no maximum age limit on covered orthodontic services for enrolled spouses.

b. Covered orthodontic services shall be paid at the 60% benefit level with the separate lifetime maximum increased to $1,500 per enrollee.

Section 2. Other Benefits:

a. Teeth cleaning should be payable three times in a fiscal year.

b. Space maintainers shall be payable for children up to age 14.

c. Bite wing x-rays shall be payable once in a fiscal year for members under 15 years of age and once every 24 months for members 15 years and older. Full mouth x-rays shall be payable once in a five-year period unless special need is shown.

d. Sealants:
Sealants are covered for permanent molars only, which must be free of restoration or decay at the time of application. Sealants are payable only up to 14 years of age. Payments will be made on a per-tooth basis. No benefit is payable on the same tooth within three years of a previous application. The dental plan will pay 50% of the reasonable and customary amount of the sealant with the employee to pay the remainder. Under the dental point of service PPO, the plan will pay 70% of the charge.

e. Oral exfoliative cytology (brush biopsy) will be covered when warranted from a visual and tactile examination.

f. Fluoride treatments shall be limited to one per fiscal year for members age 14 and younger.

Section 3. Premiums: The State will pay 95% of the premiums for employee and employee/dependent coverage.

Section 4. Dental Point of Service PPO:

Employees and dependents enrolled in the State Dental Plan may access the improved benefit levels specified below by utilizing dental care providers that are members of the Dental Point-of-Service PPO.

Benefit	Current Coverage	Enhanced Coverage
Exams	100%	100%
Preventive	100%	100%
Radiographs	90%	100%

Fillings	90%	100%
Endodontics	90%	100%
Periodontics	90%	100%
Simple Extractions	90%	100%
Complex Extractions	90%	100%
Prosthodontic Repairs	50%	100%
Other Oral Surgery	90%	90%
Adjunctive	90%	90%
Crowns	90%	90%
Fixed Bridgework	50%	70%
Partial Dentures	50%	70%
Full Dentures	50%	70%
Orthodontics	60%	75%
Annual Maximum*	$1,500	$1,500
Lifetime Orthodontics	$1,500	$1,500

The State Dental Plan's "standard" or current coverage benefit amounts are still payable when the services are provided by a non-PPO dentist.

PART C. LIFE INSURANCE

The State will continue to provide a life insurance plan with the following coverage:

Section 1. Active Employee: Coverage shall be 2.0 times basic annual salary (base hourly rate of pay, excluding all fringes, supplements and premiums, times 2088 hours) rounded upward to the nearest thousand dollars.

Section 2. Dependent Coverage: The employee may choose between five levels of dependent coverage:

a. **Level One** -- Spouse for $l,500; child(ren) for $1,000;

b. **Level Two** -- Spouse for $5,000; child(ren) for $2,500;

c. **Level Three** -- Spouse for $10,000; child(ren) for $5,000;

d. **Level Four** -- The level of coverage on the employee's spouse shall be $25,000, and the level of coverage for enrolled dependent child(ren) shall be $10,000.

e. **Level Five** -- The level of coverage for enrolled dependent child(ren) shall be $10,000.

Dependent coverage for children shall be limited to infants 15 days or older. The

optional life insurance plan shall have an age ceiling of 23 years for dependent coverage, except that there shall be no age ceiling for handicapped dependents. A dependent will be considered handicapped if he/she is unable to earn a living because of mental retardation or physical handicap and depends chiefly on the employee for support and maintenance.

The Employer shall continue to provide and pay the entire premium for the duty-connected accidental death insurance plan, which is presently in effect. The benefit level shall be $100,000.

Section 3. Retiree Coverage: An employee who retires during the term of this Agreement shall have coverage equal to 25% of the insurance in force at retirement. Dependent coverage will be in accordance with the statutory provision.

Section 4. Premiums:

a. **Active Employee** -- The State shall pay 100% of the premium for active employee coverage.

b. **Dependent Coverage** -- The employee shall pay 100% of the premium for dependent coverage.

c. **Retiree Coverage** -- The State shall pay 100% of the premium for an employee who retires during the term of this Agreement, as well as the premium for his/her spouse, if enrolled.

PART D. FLEXIBLE BENEFITS PLAN

Employees shall be eligible to participate in a Flexible Benefits Plan. The Flexible Benefits Plan will maintain the group insurance programs and options described in Parts A, B and C above, with three additional choices:

(1) A catastrophic health plan coverage option, rather than the standard health care plan or HMO coverage;

(2) A preventive dental coverage, rather than the standard State Dental Plan; and

(3) A life insurance coverage option equal to basic annual salary or $50,000 (rather than 2.0 times basic annual salary).

Employees will make individual benefit selections under the Flexible Benefits Plan using a selection form patterned after the enrollment forms used in the state's current Flexible Benefits Plan, to include:

(1) Any current individualized enrollment information on file for each employee; and

(2) The benefit selections available, including costs or prices, and incentives.

Benefit selections made by employees may be changed each year during the annual enrollment process, or when there is a change in family status as defined by the Internal Revenue Service.

Incentives are the same regardless of an employee's category of coverage. (e.g., an employee enrolled in employee-only coverage and an employee enrolled in full-family coverage will each receive the $50 refund biweekly incentive, if each elected the catastrophic health care coverage).

The amount of the incentive to be paid to employees selecting the lower level of life insurance coverage is based on an individual's annual salary and the rate per $1000 of coverage, and may therefore differ from employee to employee.

Financial incentives paid under the Flexible Benefits Plan to employees electing catastrophic health, no health care, and/or reduced life plan will be paid biweekly. Those choosing the preventive dental plan or no dental plan will receive a lump sum payment.

The amount of incentives, if any, to be paid under the Flexible Benefits Plan will be determined in conjunction with the annual rate setting process administered by the Civil Service Commission.

PART E. VISION CARE INSURANCE

The Employer will continue to provide the vision care insurance plan currently in effect for employees and employee's spouse and dependents.

Section 1. Benefits payable to participating providers will be as follows:

a. **Examination** -- Payable once in any 12-month period with an employee co-payment of $5.00.

b. **Lenses and Frames** -- Payable once in any 24 month period with an employee co-payment of $7.50 for eyeglass frames and lenses and $7.50 for medically necessary contact lenses. Lenses and frames are payable once in any 12 month period if there is a change in prescription with no change in employee co-payment.

Regular lenses up to 71 MM will be covered. If a larger lens is selected the extra size beyond 71 MM is not a covered benefit.

(1) Medically necessary means (a) the member's visual acuity cannot otherwise be corrected to 20/70 in the better eye, or (b) the member has one of the following visual conditions: Keratoconus, irregular astigmatism, or irregular corneal curvature.

(2) The payment to participating providers for eyeglass frames shall be the provider's cost or $25, whichever is less, plus dispensing fee.

c. **Non-Medically Necessary Contact Lenses** -- A maximum of $60.00, with the employee paying any additional charge. The employee co-payment provision of $7.50 under (2) above is not applicable. The payment to participating providers for contact lenses not medically necessary shall be the provider's charge or $90, whichever is less.

Section 2. Benefits payable to non-participating providers will be as follows:

a. **Vision Testing Examination** -- 75% of the reasonable and customary charge after being reduced by the employee's co-payment of $5.00.

b. **Eyeglass Frames** -- The provider's charge or $14.00, whichever is less.

c. **Eyeglass Lenses** -- The provider's charge or the amount set forth below, whichever is less:

(1) **Regular Lenses**:
Single Vision $13.00/pair
Bifocal $20.00/pair
Trifocal $24.00/pair

(2) **Contact Lenses**:
Medically necessary (as defined in b (1) above) $96.00/pair
.....
Non-medically necessary $40.00/pair

(3) **Special Lenses**: (e.g., aphotic, lenticular, aspheric):
50% of providers charge or 75% of the average covered vision expense benefits paid to participating providers for comparable lenses, whichever is less.

(4) **Additional Charge for Plastic Lenses**:
Lenses .....$ 3.00/pair
Plus benefit provided above for covered lenses.

(5) **Additional Charge for Tints**:
Equal to Rose Tint #1 and #2.....$ 3.00/pair

(6) **Additional Charge for Prism Lenses**:
Lenses ..... $ 2.00/pair

(When only one lens is required the plan will pay one-half of the applicable amount per pair shown above).

Section 3. Premiums: The State will pay 100% of the applicable premium for enrolled employees and employee/dependent coverage.

PART F. LONG TERM DISABILITY INSURANCE

Section 1. Benefit.

The State shall continue to provide the same LTD insurance program for unit employees as was provided for unit employees on the effective date of this Agreement, except that effective October 1, 2006, the eligibility period for Plan II claimants who remain totally disabled shall be reduced from age 70 to age 65, or for a period of 12-months, whichever is greater. Additionally, the benefit period for "mental/nervous" claims shall be limited to 24 months from the beginning of the time a claimant is eligible to receive benefits. This limitation does not apply to mental health claims where the claimant is under in-patient care. These changes shall only apply to new claims made after September 30, 2006. This plan provides a minimum 30-day waiting period without loss or use of sick leave after the employee completes the minimum waiting period and submits a claim for such insurance.

Section 2. Premiums.

The State shall pay 100% of the premium for such LTD insurance coverage for the term of this Agreement.

Section 3.

Employees covered by the LTD insurance shall have the exclusive option of (1) exhausting sick leave and annual leave, pursuant to Article 28, Leaves of Absence, before they are granted a medical leave of absence, or (2) they may elect to take a medical leave of absence after completion of the required 30 day minimum waiting period and freeze any accumulated, unused sick and/or annual leave.

Section 4.

The Employer shall provide a rider to the existing LTD Insurance Program. All employees who are enrolled in the LTD Insurance Program shall be automatically covered by this rider. The rider shall provide insurance which will pay directly to the carrier the full amount (100%) of health insurance (or HMO) premiums while such employee is on LTD insurance (or HMO) premiums while such employee is on LTD insurance for a maximum of six months for each covered employee. The Employer shall pay 100% of the cost of the premium for such rider.

PART G. DEFERRED COMPENSATION PLAN

All employees within the unit may exercise their rights to participate in the State of Michigan's Deferred Compensation Plans, as last adopted by the Civil Service Commission and may, during the life of this Agreement, exercise the rights and benefits under any renewed or modified Deferred Compensation Plans adopted by the Civil Service Commission. This does not include any Employer match program which may be adopted by the Civil Service Commission for any classified employees. Participation of employees within the unit in such a program is subject to negotiation between the parties.

PART H. MAINTENANCE OF INSURANCE BENEFITS

There are certain life and disability insurance programs to which the Department does not contribute or pay any premiums nor have any control over. The Employer agrees to continue permitting unit employees the convenience of voluntary payroll deductions for non-state sponsored programs (such as credit unions, charitable organizations and individual enrolled insurance programs), but only in accordance with standards by the Department of Management and Budget pursuant to, Section 283 of PA 421 of 1984. The State makes no guarantee, and assumes no liability, for the administration, benefit level or premium charges for enrollment in such programs. In addition, the State reserves the prerogative to institute or substitute alternative programs to any and all such programs, where such alternative(s) provides substantially similar (greater) benefits including, but not limited to, the option of establishing a rider on current State-sponsored insurance programs.

PART I. OPEN ENROLLMENT

There will be an annual open enrollment period for the State Health Plan PPO, Dental Plan and Vision Care Plan for employees in this bargaining unit who are eligible according to the terms of the plans.

PART J. CONTINUATION OF GROUP INSURANCES

Section 1. Layoff.

a. Subject to limitations below, employees laid off from active state employment may elect to pre-pay the employee's share of premiums for dental, vision care and life insurance (and effective 10/1/2010 Health Insurance) for the two additional pay periods after layoff by having such premiums deducted from their last paycheck. The Employer shall pay the Employer's share of premiums for health, dental, vision care and life insurance for two pay periods for all employees who elect this option.

Coverage for health, dental, vision care and life insurance shall continue for these two pay periods.

b. Employees who are laid off may, at the time of layoff, elect to continue enrollment in the Health Plan (or HMO) and life insurance plan by paying the full amount (100%) of the premium. Such enrollment may continue until the employee is recalled or for a period of three years, whichever occurs first. Such employee may also elect to continue enrollment in the dental and/or vision plan by paying the full amount (100%) of the premium. Such enrollment may continue until the employee is recalled or for a period of 18 months, whichever occurs first. In accordance with paragraph (1) of this subsection, the Employer shall pay the Employer's share of such premiums for two pay periods for employees selecting these options.

Section 2. Leave of Absence.

Employees who are granted a leave of absence may elect to continue enrollment in the Health Plan (or HMO) at the time leave begins. Such employees shall be eligible for continued enrollment during the leave of absence by paying the full amount (100%) of the premium. Such employees may also elect, at the time the leave begins, to continue enrollment in the life insurance plan for up to 12 months by paying the full amount (100%) of the premium. Such employees may likewise elect to continue enrollment in the dental plan and/or vision plan for up to 18 months by paying the full amount (100% of the premium).

Section 3. COBRA Benefits.

The State recognizes its obligations under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), in case of a qualifying event as defined by that statute.

PART K. FLEXIBLE COMPENSATION PLAN

The Employer shall maintain the current flexible compensation plan for employees in this bargaining unit. In addition, bargaining unit members shall be offered the option to participate in the State of Michigan dependent care and/or medical spending accounts authorized and established by the State in accordance with current Section 125 of the U.S. Internal Revenue Service Code.

PART L. OPTIONAL COVERAGES PROGRAM

The parties agree the Employer may extend the optional coverages program (OCP) to employees in the bargaining unit. Employees who choose to voluntarily participate in the OCP may elect to enroll in one or more of the plans offered upon the terms and conditions set forth by the provider of the specific optional coverage plan(s).

Employees who choose to not participate in the OCP will not have any optional coverages.

Premiums required for any OCP plan in which the employee enrolls are the sole responsibility of the employee. Payment may be made through payroll deduction or direct bill as permitted by the specific plan.

In the event any optional coverage plan is canceled or withdrawn, employees enrolled in the plan will be sent written notice at least 30 calendar days in advance of the coverage end date.

PART M. COMPLAINTS ABOUT BENEFITS

Any employee complaint regarding the drug quantity management program in Section 2.e of Part A shall be filed with the Civil Service Commission in accordance with civil service regulation 5.18 effective June 19, 2005.